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Request for Completion of Disability Forms

Patient Name: _____ Patient Date of Birth: _____

1. The time frames and charges for completion of Disability forms are as follows:

- A) Non-expedited completion of forms: 10 business days- \$15.00
- B) Expedited completion of forms: 5 business days- \$25.00

2. Please make sure that any forms provided to our physicians are fully completed and signed.

- A) Any forms received that are not completed cannot be processed and the above time frames will not apply.

3. Please list your occupation and a complete description of your job requirements: (i.e. stands 8 hours, lift overhead 20lbs, kneeling, bending, etc). This will assist our physicians to identify what you will be able to appropriately and safely perform at your place of employment.

Occupation: _____
Job Requirements: _____

Date completed information was dropped off: _____

Disability Dates: _____

Return to work date: _____

When form is completed Call me to pick up – (Tele #:) _____
 Fax to (Fax #:) _____
 Mail to: _____

I give my consent to have Upper Bucks Orthopaedics release my medical information to: (Please provide the name of the company that will have permission to review your medical information in regards to your disability forms)

Name of Company: _____

Signature

Date

Once all of the above information is completed on this form, our staff will proceed in completing the Disability forms in the time frame listed above.